

**Maple Valley Chiropractic and Massage**  
**23220 Maple Valley Black Diamond Rd SE, Ste 13**

**THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at Maple Valley Chiropractic and Massage, we may use or disclose personal and health related information about you in the following ways:

\*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

\*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.

\*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You can ask us not to use or share certain health information for treatment, payment, or our operations.

\*We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

\*We will say "yes" unless a law requires us to share that information.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to

confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

\*If we provide health care services to you in an emergency.

\*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

\*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

\*If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

There are extra federal confidential requirements concerning Substance Use Disorder (SUD). Although Chiropractors are generally not SUD treatment providers, such conditions may be referred to in the office, for example during medical history discussions. These records now receive heightened protection. Standard HIPAA authorizations or subpoenas may not be sufficient, and disclosures may require specific written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon

as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Ryan Donovan.

If you would like further information about our privacy policies and practices please contact Dr. Ryan Donovan.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

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This office utilizes an “open-adjusting” environment for ongoing patient care. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients may be within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

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This notice is effective as of date signed below, and I acknowledge that I have been given a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_  
Full Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party:

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of the authority to act on behalf of the patient